Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection prévue sous *la Loi de 2007 sur les foyers de soins de longue durée*

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Sep 20, 2019	2019_556168_0012	015215-19, 016344-19	Complaint

Licensee/Titulaire de permis

2063414 Ontario Limited as General Partner of 2063414 Investment LP
302 Town Centre Blvd. Suite 300 MARKHAM ON L3R 0E8

Long-Term Care Home/Foyer de soins de longue durée

Fox Ridge Care Community
389 West Street BRANTFORD ON N3R 3V9

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

LISA VINK (168), DARIA TRZOS (561), DIANNE BARSEVICH (581)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): August 15, 16, 19, 20, 21, 22, 23, 26, 27, 28, 29, 30, 2019 and September 3 and 4, 2019.

Complaint intake 015215-19 was inspected related to plan of care and skin and wound care.
Complaint intake 016344-19 was inspected related to plan of care and bathing.

Please note that the following inspections were completed concurrently with this complaint inspection:
Follow Up Inspection, Inspection number 2019_556168_0014; and

Critical Incident System Inspection, Inspection number 2019_556168_0013.

Please note a voluntary plan of correction (VPC) related to Long Term Care Homes Act (LTCHA) section (s). 6(10)b, related to the plan of care, identified in a concurrent Critical Incident System Inspection, Inspection number 2019_556168_0013, was issued in this report.

Please note a VPC related to Ontario Regulation (O. Reg.) 79/10 s. 30(2), related to general requirements, identified in a concurrent Follow Up Inspection, Inspection number 2019_556168_0014, was issued in this report.

Please note a VPC related to LTCHA s. 6(2), related to the plan of care was identified in this inspection and has been issued in Critical Incident System Inspection, Inspection number 2019_556168_0013, which was conducted concurrently with this inspection.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), the acting Director of Care (aDOC), the Assistant Director of Care (ADOC), the Resident Assessment Instrument (RAI) Coordinator, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), the Nurse Practitioner (NP), the Resident Services Coordinator (RSC), family members and residents.

During the course of the inspection, the inspectors observed the provision of care and services, reviewed documents including but not limited to incident reports, investigative notes, staff files, relevant policies and procedures and resident clinical health records.

The following Inspection Protocols were used during this inspection:
Personal Support Services
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.

- **2 WN(s)**
- **2 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Légende WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee failed to ensure that the care set out in the plan of care was provided to resident #014 as specified in the plan.

A. The plan of care for resident #014 identified they requested a specific care intervention in the event of a specified situation.
The progress notes indicated that, on an identified date, in May 2019, the resident was found in a specified situation in their room by PSW #140. They immediately reported to RPN #141, who assessed the resident and called RN #131 to the room.
The progress note stated that RN #131 assessed the resident and confirmed the situation.
The health care records indicated that the intervention was not preformed.
Documentation forwarded to a third party, in relation to actions of RPN #141, included a statement which indicated that the RPN was aware of the resident's request; however, did not feel comfortable performing the intervention by themselves.
RPN #141 and RN #131 were not able to be interviewed.
The ADOC was interviewed and stated that the intervention should have been initiated, when the resident was found, as indicated in their plan of care.

B. Resident #014's plan of care indicated that they had an area of altered skin integrity and had an order in place for a treatment, to the area, to be changed three times a week.
The electronic Treatment Administration Record (eTAR) was reviewed for the months of March, April and May 2019 and indicated that the resident did not have the treatment changed as per the physician's order on an identified date in April and May 2019.
A progress note dated, on an identified date, in April 2019, identified that the dressing

was not changed.
A progress note dated, on an identified date, in May 2019, identified that the resident was asleep and the dressing would be completed later; however, there was no documentation which indicated that it was completed.
RPN #127 was interviewed following a review of the clinical record and confirmed that the treatment was not completed as required on the identified dates.
The ADOC was interviewed and stated that the treatment should have been completed as per the physician's order on the identified dates.

Care was not provided as set out in the plan of care.

Please note: These findings of non-compliance were identified during Complaint intake 015215-19.

Please note: This evidence further supports compliance order (CO) #001, that was issued on April 29, 2019, related to the same section, of the LTCHA 2007, s. 6(7), with a compliance due date of June 3, 2019.
This non-compliance occurred prior to the compliance due date. [s. 6. (7)]

2. The licensee failed to ensure that resident #020 was reassessed and the plan of care reviewed and revised at any other time when the resident's care needs changed.

A. Review of the clinical health record identified that resident #020 used a specified mobility device and an intervention would be completed nightly.
In an interview with PSW #143, they stated the resident's own mobility device was sent out for repairs several months prior, they now used a loaner mobility device and the resident had been reassessed for a new device by the Occupational Therapist.
Review of the progress notes identified that resident's mobility device was sent for repair in June 2019, and in August 2019, they were assessed for a new device.
On a specified date in August 2019, the resident was observed with the loaner device.
Following a review of the clinical record the ADOC acknowledged the resident no longer utilized the their own mobility device and confirmed the plan of care was not reviewed and revised when their care needs changed.

B. A review of the clinical health record indicated that resident #020's routine was for specified care to be provided at a specified time daily.
During an interview with PSW #143, they stated the resident generally refused the specified care and would comply on specified days, at a time which was not consistent

with the time recorded in the record.
Following a review of the plan of care, the ADOC stated that the resident was not provided the care at the time in the record and when they did comply with the care it was at a different time.
The ADOC confirmed the plan of care was not reviewed and revised when the resident's care needs changed related their routine.

The resident was not reassessed and the plan of care reviewed and revised when their care needs changed.

Please note: These findings of non-compliance were identified during Complaint intake 016344-19. [s. 6. (10) (b)]

3. The licensee failed to ensure that resident #001 was reassessed and the plan of care reviewed and revised at any other time when the care set out in the plan was no longer necessary.

Review of the clinical health record identified that resident #001 was diagnosed with an injury in July 2019, which was managed with the application of an intervention.
Review of the written plan of care identified that the intervention was to be in place on all shifts and removed each shift for an assessment.
Review of the physician's orders indicated that the intervention was discontinued on an identified date in August 2019.
Following a review of the plan of care, RPN #127 confirmed that the intervention had been discontinued and was no longer required to manage the injury.

The plan of care was not reviewed and revised when care set out in the plan of care was no longer necessary.

Please note: This finding of non-compliance was identified during Critical Incident System Inspection intake 014845-19. [s. 6. (10) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance ensure that the resident is reassessed and the plan of care reviewed and revised at any other time when the resident's care needs change or care set out in the plan is no longer necessary, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that any actions taken with respect to resident #002 and #020 under the skin and wound program, including interventions were documented.

Ontario Regulation 79/10 s. 48(1)2 noted that a skin and wound program was a required program.

A. Review of the clinical record for resident #002 identified that they had altered skin integrity which was first identified on an identified date in August 2019.
The clinical record included a reassessment of the area, on an identified date in August 2019, by RPN #127; however, did not include documentation of the treatment provided since it was first identified.
Interview with RPN #127 confirmed that at the time of the reassessment they removed the previous treatment and applied a new treatment.
Following a review of the eTAR, the RPN, confirmed that the treatment provided on a specified date in August 2019, was not documented in the clinical record.
The ADOC reviewed the recent skin and wound assessments along with the eTAR, for August 2019, and confirmed that the treatment, an intervention completed weekly, since

it was initiated in August 2019, had not been documented as required.

B. A review of the eTAR for resident #020 identified that they required a treatment to be applied as needed and to use when specified care was provided once or twice a day.
Interview with PSW #107 stated they provided the specified care twice a week and used the treatment.
A review of the eTAR from February to August 2019, included that the treatment was only provided on a specified date in March 2019.
Following a review of the eTAR, the acting DOC confirmed that the treatment was not documented when provided except on the identified date in March 2019. They acknowledged that the treatment was not identified as a task under "support actions" in Point of Care for the PSW's to document when the treatment was provided and confirmed the registered staff should have documented in the eTAR when the treatment was provided two times a week.

Actions taken with respect to a resident under a program, including interventions were not documented.

Please note: These findings of non-compliance were identified during Follow Up intake #032837-18. [s. 30. (2)]

2. The licensee failed to ensure that any actions taken with respect to resident #014 under a program, including interventions and the resident's responses to interventions were documented.

The home had a policy for a specified intervention which identified that the nurse, upon learning of resident's need for the intervention, would obtain a physician's/NP's order, which included directions for use and frequency. The plan of care would include specific information and direction regarding the intervention.

A. The plan of care for resident #014 identified that they used the intervention at a specific time.
The order for the intervention was not included on the electronic Medication Administration Record (eMAR), nor were the directions for use documented in the plan of care.
PSW #146 and RPN #127 were interviewed and confirmed that the resident utilized the intervention; however, refused it at times.
PSW #140, who provided direct care to the resident on the day shift, stated that they did

not observe the resident with the intervention in place.
The written plan of care was reviewed and did not include that the resident refused to use the intervention as ordered.
The ADOC was interviewed and confirmed the use of the intervention was not documented in the eMAR, that the specifics for use were not documented in the plan of care and that the resident's response to the intervention, their refusal, should have been documented.

B. Resident #014's clinical records were reviewed and the physician's order on an identified date in April 2019, stated that the RSC was to assist the resident to contact a third party for an intervention for a specified reason.
The RSC identified that they provided the phone number of the third party to the resident; however, they did not assist to contact them, as the resident refused their assistance.
Clinical records did not include documentation of the actions taken by the RSC.
The RSC confirmed that they did not document their actions nor the resident's response.
The ADOC was interviewed and confirmed that the actions of the RSC should have been documented in the resident's clinical record.

The licensee failed to ensure that interventions and responses to the interventions related to the intervention were documented.

Please note: These findings of non-compliance were identified during Complaint intake 015215-19. [s. 30. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that any actions taken with respect to a resident including interventions and the resident's response to interventions are documented, to be implemented voluntarily.

Issued on this 25th day of September, 2019

Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs

Original report signed by the inspector.